June 4, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday June 11, 2020, in the Kaweah Delta Support Services Building Copper Room (2nd floor) 520 West Mineral King Avenue or via GoTo Meeting form your computer, tablet or smartphone. https://global.gotomeeting.com/join/405843725 or call (646) 749-3122 - Access Code: 405-843-725.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01Am on Thursday, June 11, 2020, in the Kaweah Delta Support Services Building Copper Room pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting immediately following the 7:01AM Closed meeting on Thursday June 11, 2020, in the Kaweah Delta Support Services Building Copper Room or via GoTo Meeting via computer, tablet or smartphone. https://global.gotomeeting.com/join/405843725 or call (646) 749-3122 - Access Code: 405-843-725.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID-19 visitor restrictions to the Medical Center – the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 and on the Kaweah Delta Health Care District web page https://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board Legal Counsel Executive Team Chief of Staff
http://www.kaweahdelta.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, June 11, 2020

520 Mineral King Ave

Copper Room, 2nd Floor Support Services Building

GoTo Meeting: https://global.gotomeeting.com/join/405843725

Call in option: 1-646-749-3122 Access Code: 405-843-725

ATTENDING: Board Members; Herb Hawkins – Committee Chair, David Francis; Gary Herbst, CEO; Regina Sawyer, RN, VP & CNO; Anu Banerjee, PhD, VP & Chief Quality Officer, Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

1. **Call to order** – *Herb Hawkins, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Open Meeting** – *Herb Hawkins, Committee Chair*

CLOSED MEETING – 7:01AM

1. **Call to order** – *Herb Hawkins, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 — *Anu Banerjee, PhD, VP & Chief Quality Officer*

4. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

OPEN MEETING – Immediately following the 7:01AM Closed Meeting

1. **Call to order** – *Herb Hawkins, Committee Chair*

2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. **Value-Based Purchasing**
   - 3.2. **Patient Experience Report**

4. **Emergency Department Quality Report** - A review of current performance measures and top priority actions focused on care in the Emergency Department. *Kona Seng, OD, Medical Director of Emergency Services, and Tom Siminski, RN, Director of Emergency Services.*

5. **Update: Fiscal Year (FY) 2020 Clinical Quality Goals** - A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*

6. **Hospital Acquired Pressure Injury (HAPI) Quality Focus Team Report –** A review of outcome, process measures and action plans related to the prevalence and prevention of HAPI. *Mary Laufer, RN, DNP, Director of Nursing Practice.*

7. **Adjourn** – *Herb Hawkins, Committee Chair*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.

Value Based Purchasing Fiscal Year 2021

Anu Banerjee, PhD, VP/CQO

Abbreviations

- CMS: Centers for Medicare and Medicaid Services
- DRG: Diagnosis Related Groups
- FY: Fiscal Year
- CY: Calendar Year
- TPS: Total Performance Score
- VPB: Value Based Purchasing
- CHA: California Hospital Association
- CAUTI – Catheter Associated Urinary Tract Infection
- CLABSI – Central Line Associated Blood Stream Infection
- COPD – Chronic Obstructive Pulmonary Disease
- MRSA - Methicillin-resistant Staphylococcus aureus

VBP Payment Method

- *"The Hospital VBP Program is funded by a 2% reduction from participating hospitals' base operating diagnosis-related group (DRG) payments for FY 2018.*
- *Resulting funds are redistributed to hospitals based on their Total Performance Scores (TPS).*
- *The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY.*
- *It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year."*

CMS Quality Patient Assessment Instruments

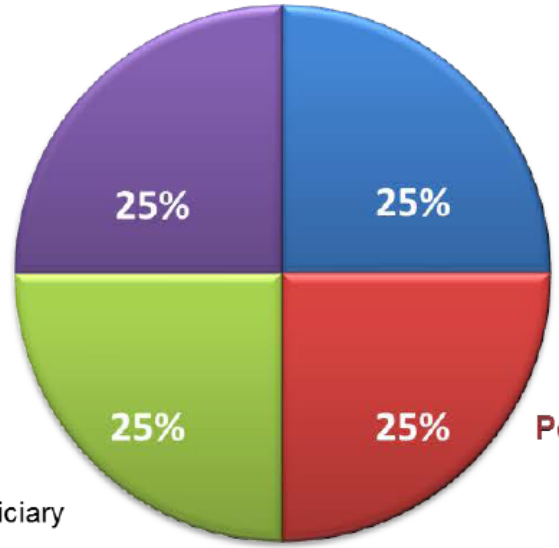
Value Based Purchasing Measures Fiscal Year 2021

- Payment adjustment effective for discharges from Oct 1, 2020 and Sept 30, 2021
- For outcomes reported in CY 2019 (Safety, Efficiency and Engagement Domains) and July 1, 2016 through June 30, 2019 for Clinical Care Domain

Safety

1. **CDI**: Clostridium difficile Infection
2. **CAUTI**: Catheter-Associated Urinary Tract Infection
3. **CLABSI**: Central Line-Associated Bloodstream Infection
4. **MRSA**: Methicillin-Resistant *Staphylococcus aureus* Bacteremia
5. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy

Domain Weights



Clinical Care

1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate
4. **THA/TKA**: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

Efficiency and Cost Reduction

1. **MSPB**: Medicare Spending per Beneficiary

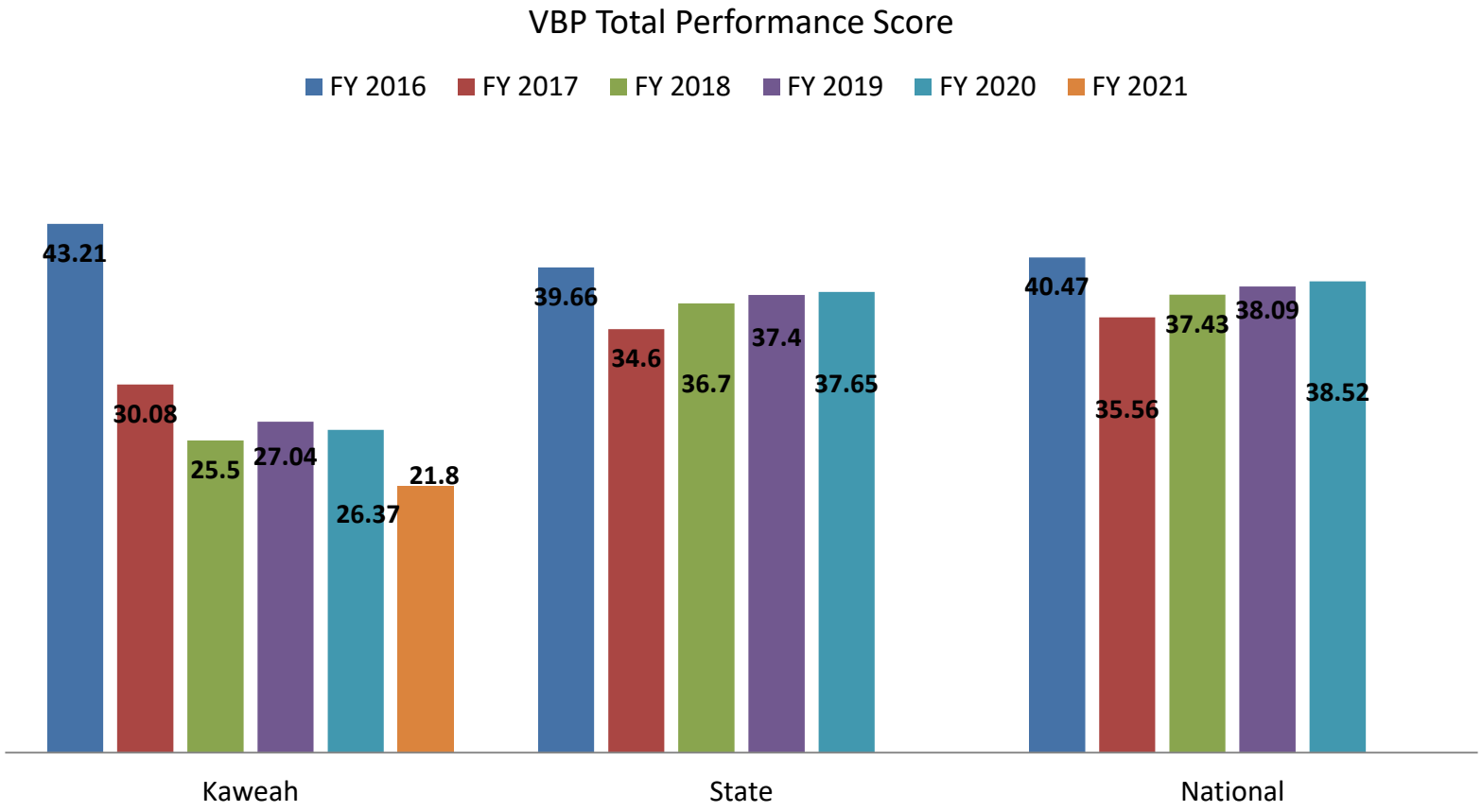
Person and Community Engagement

HCAHPS Survey Dimensions

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition
8. Overall Rating of Hospital

Kaweah Delta Performance - FY 2021 Payment Performance

*State and National Performance Scores not yet Available



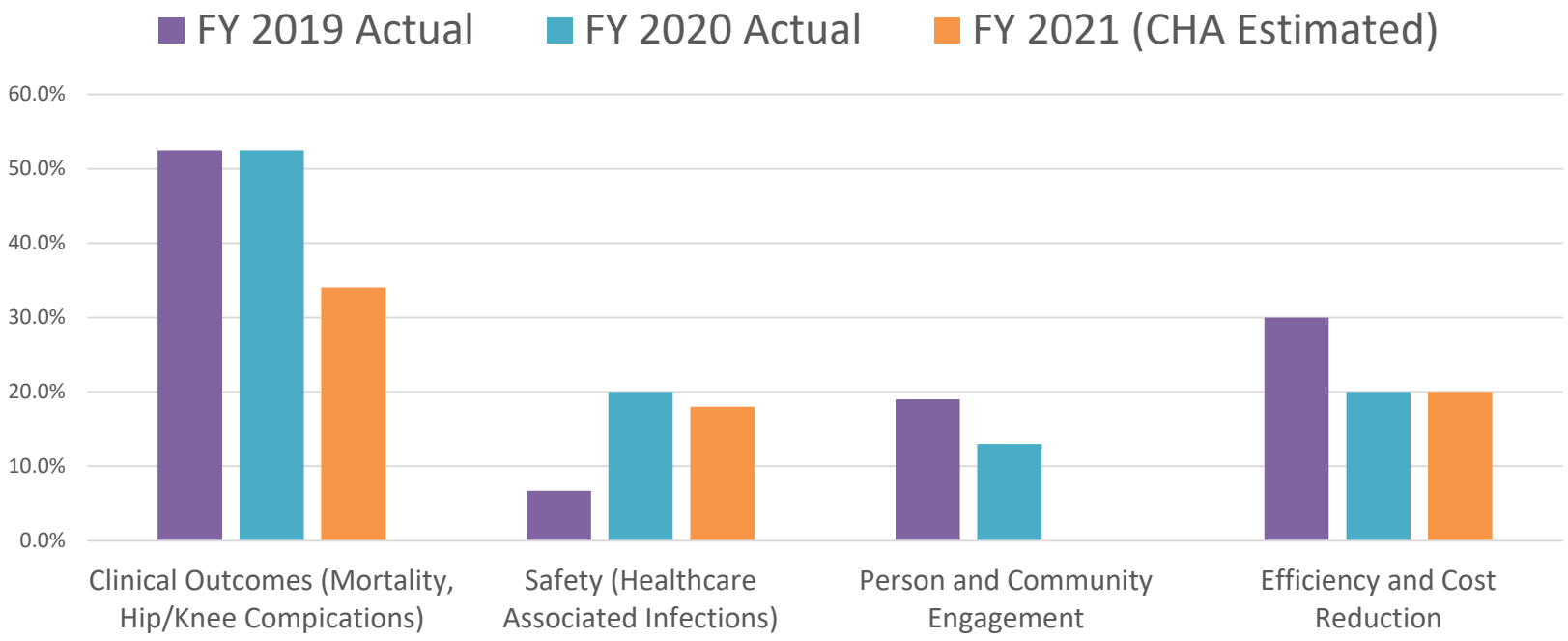
FY 2021 CHA ESTIMATED VBP Cost Analysis	
Contribution	Payment Percentage
2% = $1,889,800	1.48% = $1,397,900
($491,900)	

CHA Estimated VBP Points by Domain

Domains	FY 2021 (CHA Estimated Points out of 10 Possible)
Clinical Outcomes - Domain Score (% of all points possible for this 25% of VBP)	**34%**
Acute Myocardial Infarction	5
Heart Failure	1
Pneumonia*	2
COPD	2
Complication elective Total Hip/Knee	7
Safety - Healthcare Associated infections - Domain Score (% of all points possible for this 25% of VBP)	**18%**
CLABSI - Per 1000 line days*	0
CAUTI - Per 1000 catheter days*	1
SSI Surgical Site Infection	1
SSI Colon - Rate Per 100 procedures	1
C. difficile - Per 10,000 patient days	7
MRSA - Per 10,000 patient days	1
Person and Community Engagement - Domain Score (% of all points possible for this 25% of VBP)	**15%****
Communication with Nurses	0
Communication with Doctors	0
Responsiveness of Hospital Staff	0
Communication about Medicines*	0
Cleanliness of Hospital Environment	0
Quietness of Hospital Environment*	0
Discharge Information	0
Care Transition	0
Overall Rating of Hospital*	0
Efficiency and Cost Reduction-Domain Score (% of all points possible for this 25% of VBP)	**20.00%**
Medicare Spending per Beneficiary	2

*Largest opportunity for Improvement
**Consistency Score

FY Comparision for VBP Domain Scores
% of all Points Possible for the 25% Domain



Action Plan & Teams

Mortality

- Mortality committee meets once month and has identified the largest improvement opportunity is earlier palliative care. Disease specific resource effectiveness teams are also working on best practices.

Hip & Knee Complications

- Orthopedic service line reviews all complications to assess if complications are true (re-code) and identify opportunities for improvement. Initiating Enhanced Recovery After Surgery (ERAS) program in 2020 which aims to reduce complications and decrease length of stay through implementation of evidenced-based care pathways.

Infection Prevention

- Infection prevention committees implement best practices for each measure. CAUTI and CLBASI Kaizen Events (Rapid Improvement) in Jan and Feb 2020 with robust action plans implemented. IV safety team continues round on all lines and monitor expired IVs. Hand Hygiene (HH) monitoring system (Biovigil) currently piloting in 2 units with HH rates greater than 98%.

Patient Experience

- Continued implementation of "Operation Always" with department specific action plans, increased leader patient rounding, and use of new survey vendor in July 2019.

Medicare Spending

- Resource Effectiveness Committee and teams in place and reorganizing structure to maximize heightened focus on biggest opportunities to reduce costs.

Questions?

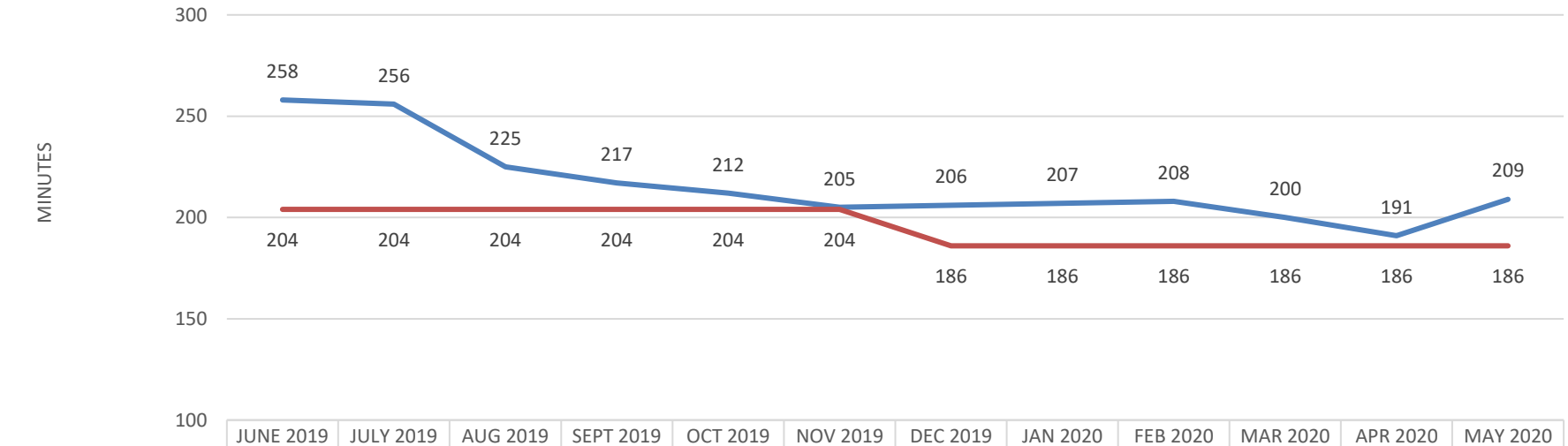
Patient Experience (HCAHPS) Performance: World-Class Service
April 2020

Time Period	3Q18 -2Q19		July – Dec 2019	
HCAHPS Measure	**Full Adj**	**CMS** 50th percentile	**Mode Adj**	**Comments/Improvement Efforts**
	-	-	-	-
# of surveys 22% response rate	1660	-	921	-
Communication with Nurses	**77%** Below CMS	81%	79%	1) Introductions and closing encounters 2) Share the care 3) Communication white boards
Communication with Doctors	**75%** Below CMS	82%	79%	1) Greet patients/companions with smile 2) Sit at the bedside 3) Conclude with "Is there anything else I can do for you?"
Responsiveness of Staff	**64%** Below CMS	70%	72%	1) Hourly Rounding 2) Proactive toileting
Communication about Meds	**60%** Below CMS	66%	66%	1) Medicine Guide
Cleanliness of Environment	**66%** Below CMS	76%	74%	2) Leader Rounding 3) Increased surveillance
Quietness of Environment	**48%** Below CMS	62%	55%	*No new interventions*
Discharge Information *(Yes)*	**84%** Below CMS	87%	90%	1) Medicine Guide 2) Patient Guide 3) Discharge advocates meet with admits r/t preferences and expectations 4) NRC Discharge Phone Calls 5) Rebuild Discharge Instructions
Care Transition *(Strongly Agree)*	**45%** Below CMS	53%	50%	*Same as above*
Overall Rating of Hospital **(0 = worst; 10 = best)**	**70%** ***(9 or 10)*** Below CMS	73%	75%	**OPERATION ALWAYS** *Purpose: Consistently provide world-class service* **→Increase leader rounding on patients** **→Build consistent Service Standards across units and divisions** → Gold Star Discharge Program (early discharges home) →Pursue Unity & Consistency
Willingness to Recommend ***(Definitely Recommend)***	**69%** Below CMS	72%	73%	*Same as above*

Kaweah Delta
HEALTH CARE DISTRICT

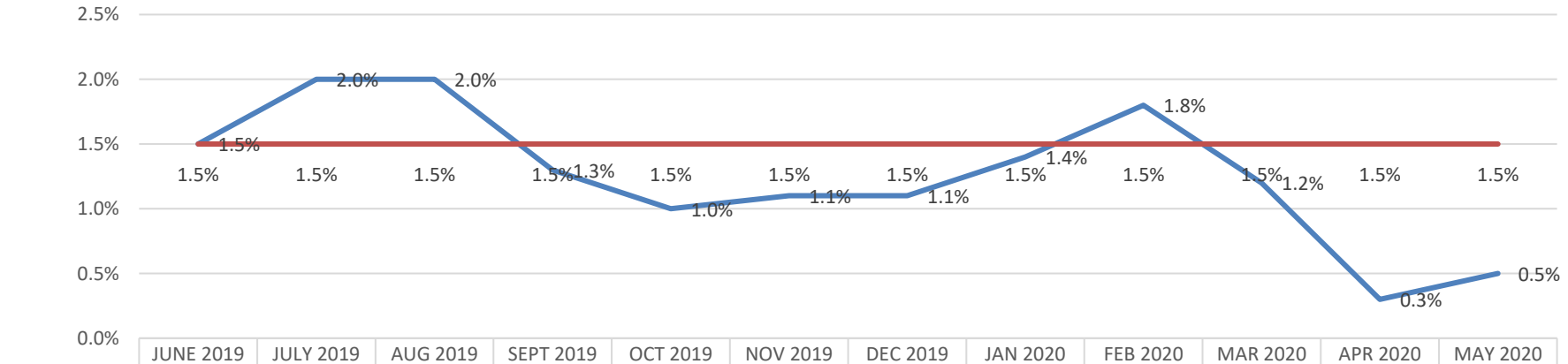
GENERAL METRICS	MARCH 2020 KDHCD	GOAL	APRIL 2020 KDHCD	GOAL	MAY 2020 KDHCD	GOAL
ED Volume	5955		4174		5033	
Percent of Patients Left Without Being Seen	1.2%	1.5%	0.3%	1.5%	0.5%	1.5%
Percent of Patients Left During Treatment	2.1%	1.5%	1.1%	1.5%	2.0%	1.5%
Percent of Patients Left Against Medical Advice	1.1%	NA	1.0%	NA	1.0%	NA
Percent of Patients Admitted	25%	NA	29%	NA	29%	NA
Percent of Patients Discharged	67%	NA	64%	NA	63%	NA
		CMS State		CMS State		CMS State
ED THROUGHPUT METRICS		Benchmark		Benchmark		Benchmark
Median Length of Stay in Minutes for Admitted Patient (Hours)	445 (7.42)	407 (6.8)	376 (6.26)	407 (6.8)	410 (6.8)	407 (6.8)
Median Length of Stay in Minutes for Discharged Patient (Hours)	200 (3.3)	186 (3.1)	191 (3.2)	186 (3.1)	209 (3.5)	186 (3.1)
Median Length of Stay in Minutes for Admit Decision to ED Depart (Hours)	244 (4.1)	197 (3.3)	206 (3.4)	197 (3.3)	222 (3.7)	197 (3.3)
Average Length of Stay in Minutes for Admitted Mental Health Patients (Hours)	657 (10.9)		810 (13.5)		791 (13.2)	
CENSUS TOTALS BY DISPOSITION						
Number of Patients Arriving by Ambulance	1793		1501		1622	
Number of Trauma Patients	162		141		163	
Number of Patients Admitted	1504		1222		1465	
Number of Patients Discharged	4006		2672		3183	
Number of Mental Health Patients Admitted	70		90		108	
PATIENT EXPERIENCE		GOAL		GOAL		GOAL
*90TH PERCENTILE Emergency Room Overall Care Percent 9S-10S	64.36%	62%	72.77%	62%	62.86%	62%
Would Recommend Percent Definitely YES	77.42%	76%	87.56%	76%	79.25%	76%
KEY	> 10% Above Benchmark/Goal		Within 10% of Benchmark/Goal		Outperforming or Meeting Benchmark/Goal	

2019-2020 LENGTH OF STAY - DISCHARGED PATEINTS (MEDIAN)



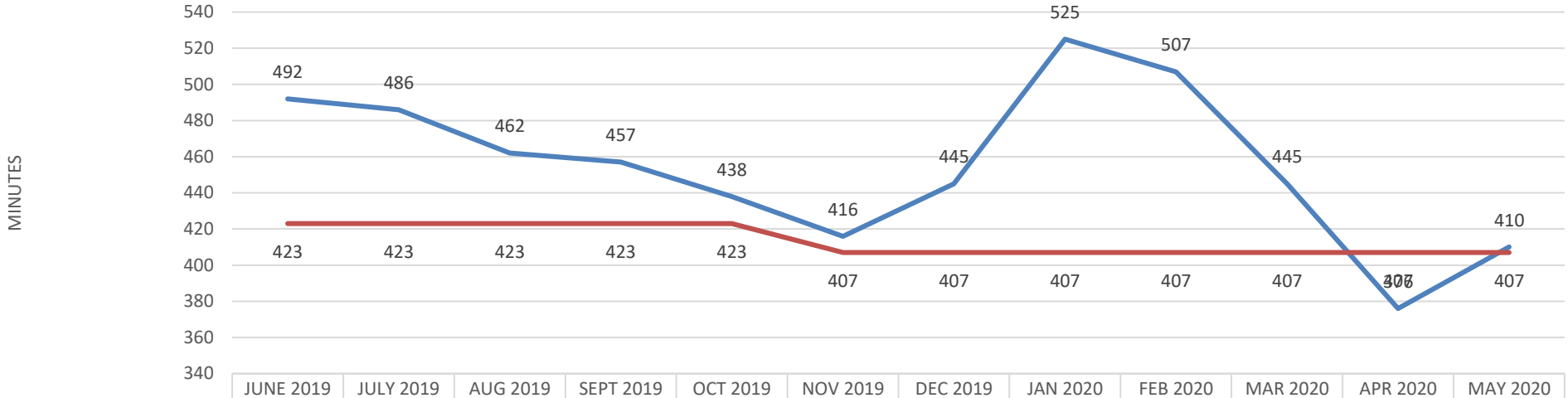
	JUNE 2019	JULY 2019	AUG 2019	SEPT 2019	OCT 2019	NOV 2019	DEC 2019	JAN 2020	FEB 2020	MAR 2020	APR 2020	MAY 2020
DISCHARGE LOS	258	256	225	217	212	205	206	207	208	200	191	209
CMS BENCHMARK	204	204	204	204	204	204	186	186	186	186	186	186

2019-2020 ED % PATIENTS THAT LWOT



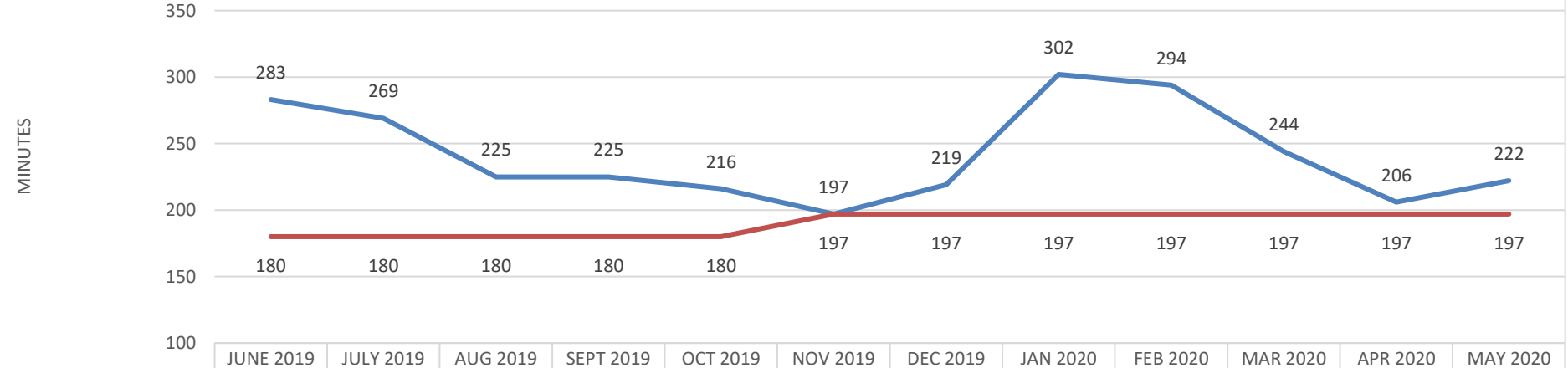
	JUNE 2019	JULY 2019	AUG 2019	SEPT 2019	OCT 2019	NOV 2019	DEC 2019	JAN 2020	FEB 2020	MAR 2020	APR 2020	MAY 2020
%LWOT	1.5%	2.0%	2.0%	1.3%	1.0%	1.1%	1.1%	1.4%	1.8%	1.2%	0.3%	0.5%
GOAL	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%

2019-2020 LENGTH OF STAY - ADMITTED PATIENTS



	JUNE 2019	JULY 2019	AUG 2019	SEPT 2019	OCT 2019	NOV 2019	DEC 2019	JAN 2020	FEB 2020	MAR 2020	APR 2020	MAY 2020
ADMITS LOS	492	486	462	457	438	416	445	525	507	445	376	410
CMS BENCHMARK	423	423	423	423	423	407	407	407	407	407	407	407

2019-2020 ADMIT DECISION TO ED DEPART- ADMIT PATEINTS (MEDIAN)



	JUNE 2019	JULY 2019	AUG 2019	SEPT 2019	OCT 2019	NOV 2019	DEC 2019	JAN 2020	FEB 2020	MAR 2020	APR 2020	MAY 2020
ADM DEC TO DEP	283	269	225	225	216	197	219	302	294	244	206	222
CMS BENCHMARK	180	180	180	180	180	197	197	197	197	197	197	197

Emergency Department

Quality Project Update on Strategies for Improvement

Date: June 11th,2020

Time: 700a

Strategies for Improvement:

Patient Satisfaction:

- Daily ED Leadership Rounding on Patients and Staff to provide real-time service recovery and recognition (Enter into My Rounding)
- ED Nursing and Physician Leadership phone calls to provide follow up and service recovery to patients and families
- ED staff to adhere to the Standards of Behavior

Throughput:

- Continue to work on getting data in regards to imaging and lab turnaround times to assess for areas of delay and to identify opportunities for performance improvement
- Continue to work with Mental Health Leadership to improve the triage and disposition of Mental Health patients and to decrease length of stay
- Continue to investigate options to help facilitate throughput and significantly decrease length of stay for discharged patients and admitted patients
- Continue to work on strategic plans to address times of patient surge
- Work on the development of an ED call center

Sepsis Treatment:

- Schedule ED and GME education/awareness of Sepsis Bundle and order set usage
- Initiate Sepsis Order set and follow appropriately
- Develop electronic checklist reminder for RN when order set is used

Kaweah Clinical Quality Goals

June 2020

Sepsis **Kaweah Clinical Quality Goal Calculator - FY20**

	Current										Future State Scenario			FYTD	Baseline	Goal	Top 10% = 81% (Q3 2018 - Q2 2019)
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	**April 2020**	May 2020	June 2020	**Total**	**Total**			
SEP-1 Early Management Bundle	68%	67%	58%	67%	61%	74%	54%	75%	61%	**85%**	88%	88%	70%	**67%**	**67%** **0%**	**70%**	
numerator	13	16	14	20	17	17	14	18	14	**22**	22	22	209	165			
denominator	19	24	24	30	28	23	26	24	23	**26**	25	25	297	247			

Sepsis Six Sigma:

- Root causes identified, 21 QI strategies developed and prioritized to improve processes to ensuring patients get all components of the bundle every time
  - NEW! Evaluate all Sepsis education and reformat required fundamentals training
- 2nd Sepsis Coordinator started 5/17, help from light duty and other Quality & Patient Safety staff starting in April

Sepsis Quality Improvement Strategies

Project Prioritization Matrix: Sepsis QFT, June 2020

Group Strategy Affects	Improvement Strategy		DIFFICULTY or Cost/ Time to Implement Rate 5 to 1 High = 1 Low = 5		FEASIBILITY (likelihood of Success/ability to achieve the outcome Rate 5 to 1 High = 5 Low = 1		SCOPE Strategy affects multiple or a high volume root cause Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Positive Impact on Other Processes) Rate 5 to 1 High = 5 Low = 1	**Total Project Priority**
ED Pro	2. ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out") **COMPLETE**	x	4.0	x	5.0	x	5.0	x	5.0	**500.0**
CC/INPT RN	6. Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion **IN PROCESS**	x	2.0	x	4.0	x	4.0	x	5.0	**160.0**
ED Pro & CC/HOS	11. Build dot phrase - If it's not Sepsis, document it **COMPLETE**	x	4	x	2	x	4	x	5	**160.0**
ED Pro/ ED GME	9. Schedule ED and GME regular education/awareness of bundle, and order set usage **IN PROCESS**	x	2	x	4	x	4	x	4	**128.0**
ED Pro	1. Improve ED provider notification by Sepsis Coordinator when attempting to avoid fallouts concurrently **IN PROCESS**	x	4.0	x	2.0	x	4.0	x	3.5	**112.0**
ED/CC RN	20. Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete. **IN PROCESS**	x	3	x	2	x	4	x	4	**96.0**
CC/INPT RN	7. Mandatory for RN to fill out "provider notification form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts. **THIS IS DEPENDENT ON #6** Investigate what happens If you bypass the alert one time it appears very difficult to get it back – further education/awareness of where to find alert. **IN PROCESS**	x	4.5	x	3.0	x	2.0	x	3.0	**81.0**
CC/INPT RN	10. (Q&P/S) obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements **COMPLETE**	x	4	x	3	x	2	x	3	**72.0**

ED = Emergency Department; Pro = Provider; CC = Critical Care; GME= Graduate Medical Education; HOS = Hospitalist; INPT = Inpatient

CAUTI, CLABSI & MRSA

Kaweah Clinical Quality Goal Calculator - FY20

CAUTI = Catheter Associated Urinary Tract Infection; CLABSI = Central Line Associated Blood Stream Infection; MRSA = Methicillin-resistant Staphylococcus aureus

	Current									Future State Scenario			FYTD			
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total*	Total	Baseline 1.557 ↓38%	SIR GOAL ≤0.828 or 14	VBP 2022 50 perc ≤0.727
CAUTI (SIR)	0.65	2.76	2.34	0.68	0.00	0.00	0.00	1.24	0.00	0.00	0.00	0.00	**0.70**	**0.96**			
numerator (actual)	1	5	4	1	0	0	0	2	0	0	0	0	13	13			
denominator (predicted)	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.61	1.24	1.5	1.5	1.5	18.06	13.56			
Denominator (Actual 9 months + Predicted Apr - Jun) Linear Regression	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.61	1.24	1.69	1.62	1.58	18.45				

***Linear regression used for prediction - it does not consider number of catheter days as it is unknown and variable each month**

	Current									Future State Scenario			FYTD			
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total*	Total	Baseline 1.253 ↓33%	SIR GOAL <0.784 or 12	VBP 2022 50 perc ≤0.633
CLABSI (SIR)	0.00	0.00	2.70	3.67	1.11	0.00	0.00	0.00	0.00	0.82	0.00	0.00	**0.68**	**0.81**			
numerator (actual)	0	0	3	4	2	0	0	0	0	1	0	0	10	10			
denominator (predicted)	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.22	1.22	1.22	14.72	12.28			
Denominator (Actual 9 months + Predicted Apr - Jun) Linear Regression	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.22	1.23	1.23	14.74	0.68			

***Linear regression used for prediction - it does not consider number of central line days as it is unknown and variable each month**

	Current										Future State Scenario		FYTD			
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total	Total	Baseline 1.410 ↑6%	SIR GOAL <0.815 or 7	VBP 2022 50 perc ≤0.748
MRSA (SIR)	2.67	1.33	1.33	0.00	0.00	2.78	0.00	1.89	1.89	2.99	0.00	0.00	**1.25**	**1.50**			
numerator (actual)	2	1	1	0	0	2	0	1	1	2	0	0	10	10			
denominator (predicted)	0.75	0.75	0.75	0.72	0.72	0.72	0.53	0.53	0.53	0.67	0.67	0.67	8.01	6.67			

Kaizen Six Sigma Improvement Strategy Examples:

* Culture of culturing
- Catheter and Central Line Gemba Rounds ongoing daily, including handoff elements, best practice compliance data collected and disseminated
- Enhanced shift huddles, education and awareness of bundles

“Culture of Culturing”
(aka Culturing Stewardship)

CLABSI Kaizen Action Plan - Culture of Culturing Team

#	Task	Original Due Date	Status
1	Cerner alert pop-up for blood cultures ordered within 24 hours apart (SOFT STOP, drop down option to clarify need for order)	2/24/20	
2	Report build to track and trend over-rides (dependent on #1)	2/24/20	
3	One Page Wonder of Culturing Guidelines	2/24/20	
4	CL Tip Culture: “Not Available in Kaweah Delta Laboratory“ * Removal of all references to catheter tip culture	2/24/20	
5	New Insert CL order set, phased Power Plan, with alert for physicians for “line OK to use”	3/6/20	

Hospital Acquired Pressure Injury (HAPI) Prevention Quality Focus Team June 2020 Report

Mary Laufer, DNP, RN, NE-BC
Director of Nursing Practice
Quality Council

KAWEAH DELTA HEALTH CARE DISTRICT

Hospital-Acquired Pressure Injury

- HAPI (formerly known as a “pressure ulcer”)
- Localized injury to the skin and/or underlying tissue during an inpatient hospital stay
- Resulting from pressure and/or shear forces that damage tissue

Hospital-Acquired Pressure Injury

- Usually over a bony prominence
- Or, related to a medical or other device
- Injury may present as intact skin or an open ulcer, and may be painful

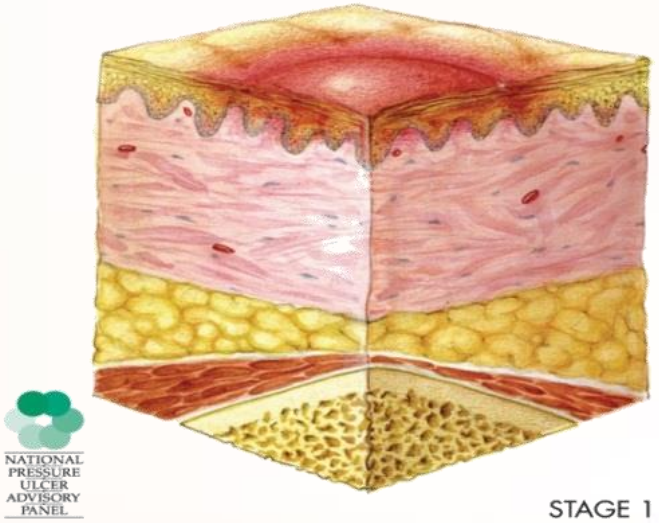
Apples to Ulcers / Injuries

Pressure Injury Staging: Educational Comparison Tool*

**Patent Pending – Patty Turner, BSN, RN, CWOCN, CSW*111/125

Stage 1

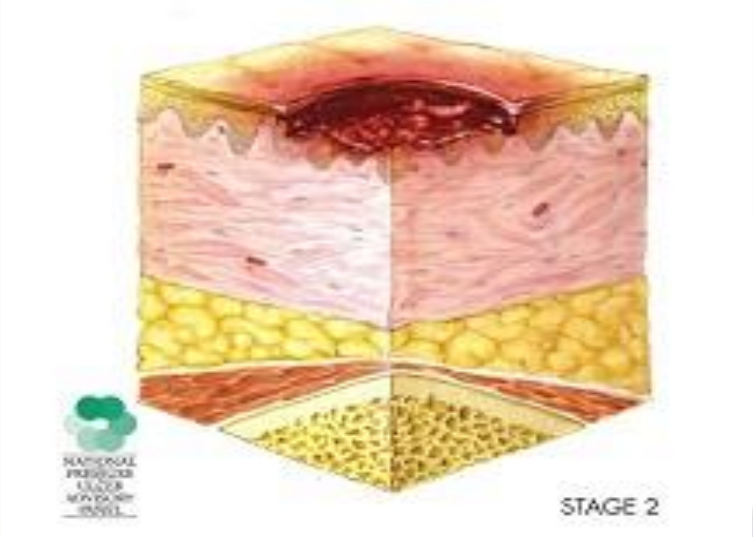
- Intact skin with a localized area of non-blanchable redness (erythema)



*NPUAP, 2016; *Patent Pending – Patty Turner, BSN, RN, CWON, CSW*

Stage 2

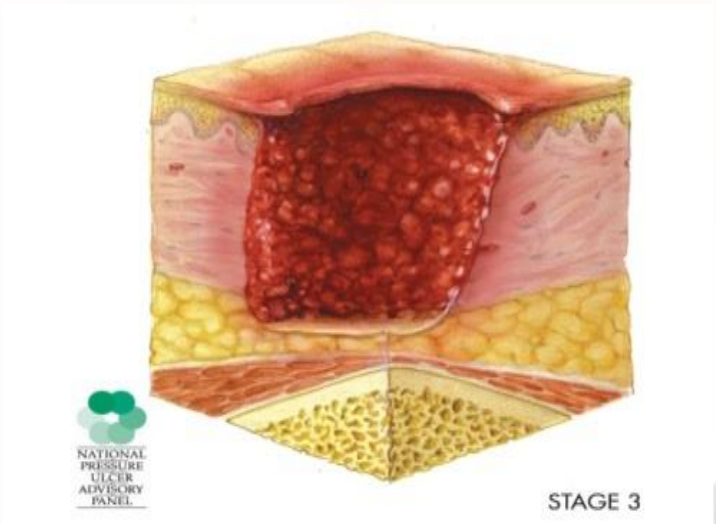
- Partial-thickness loss of skin with exposed dermis. Wound bed is visible, pink or red, moist, may be an intact or ruptured fluid-filled blister



*NPUAP, 2016; *Patent Pending – Patty Turner, BSN, RN, CWON, CSW*

Stage 3

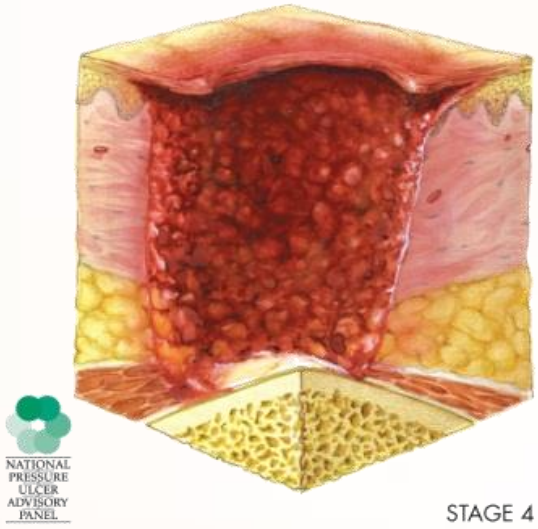
- Full-thickness loss of skin with fat (adipose) visible, rolled wound edges (epibole) often present, dead (necrotic) tissue may be visible



*NPUAP, 2016; *Patent Pending – Patty Turner, BSN, RN, CWOCN, CSW*

Stage 4

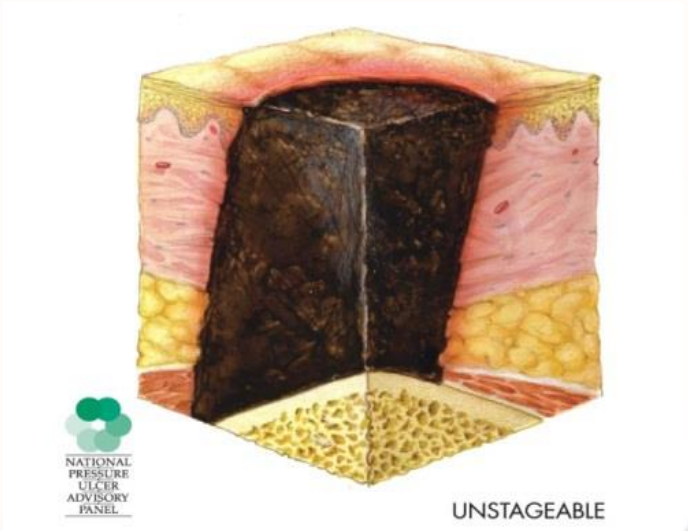
- Full-thickness skin/tissue loss with exposed fascia, muscle, tendon, ligament, cartilage or bone in ulcer, necrotic tissue (slough, eschar) may be visible



*NPUAP, 2016; *Patent Pending – Patty Turner, BSN, RN, CWOCN, CSW*

Unstageable

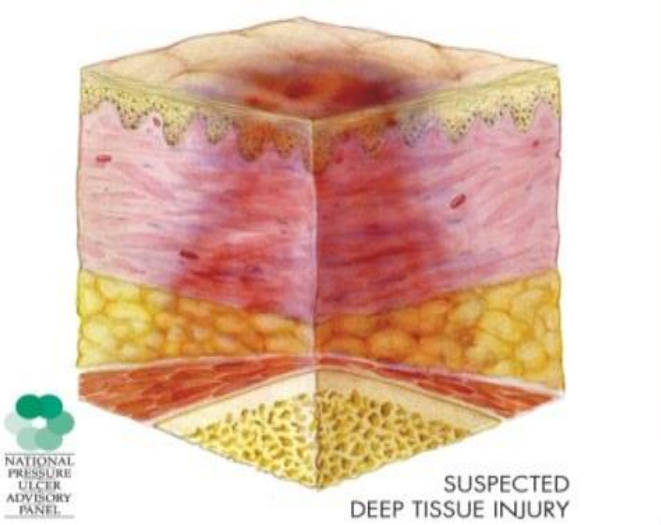
- Full-thickness skin/tissue loss in which extent of tissue damage within ulcer is not confirmed because it is obscured by necrotic tissue (slough, eschar)



*NPUAP, 2016; *Patent Pending – Patty Turner, BSN, RN, CWOCN, CSW*

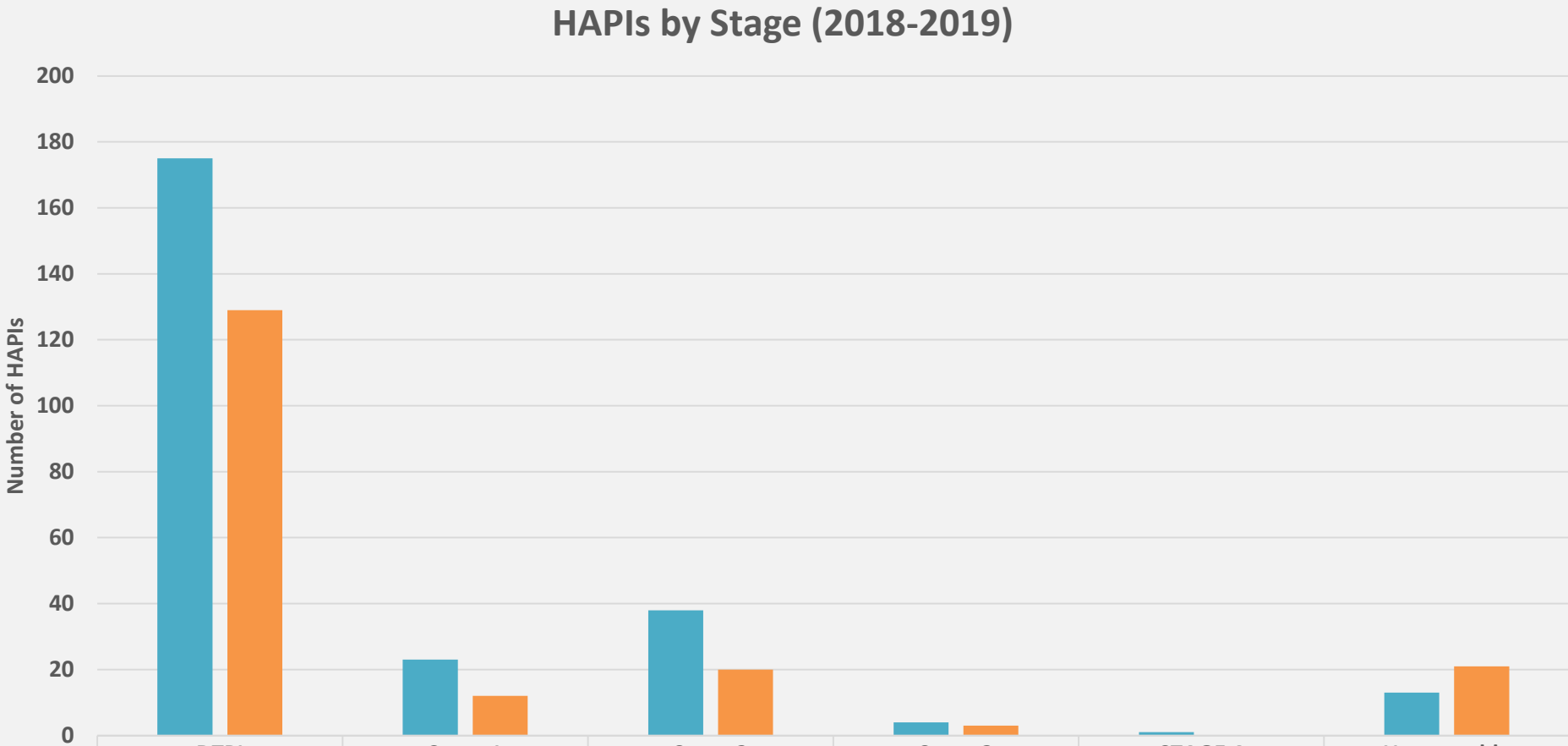
Deep Tissue Pressure Injury (DPTI)

- Intact or non-intact skin with local area of persistent non-blanchable deep red, maroon, purple discoloration, blister over dark wound bed



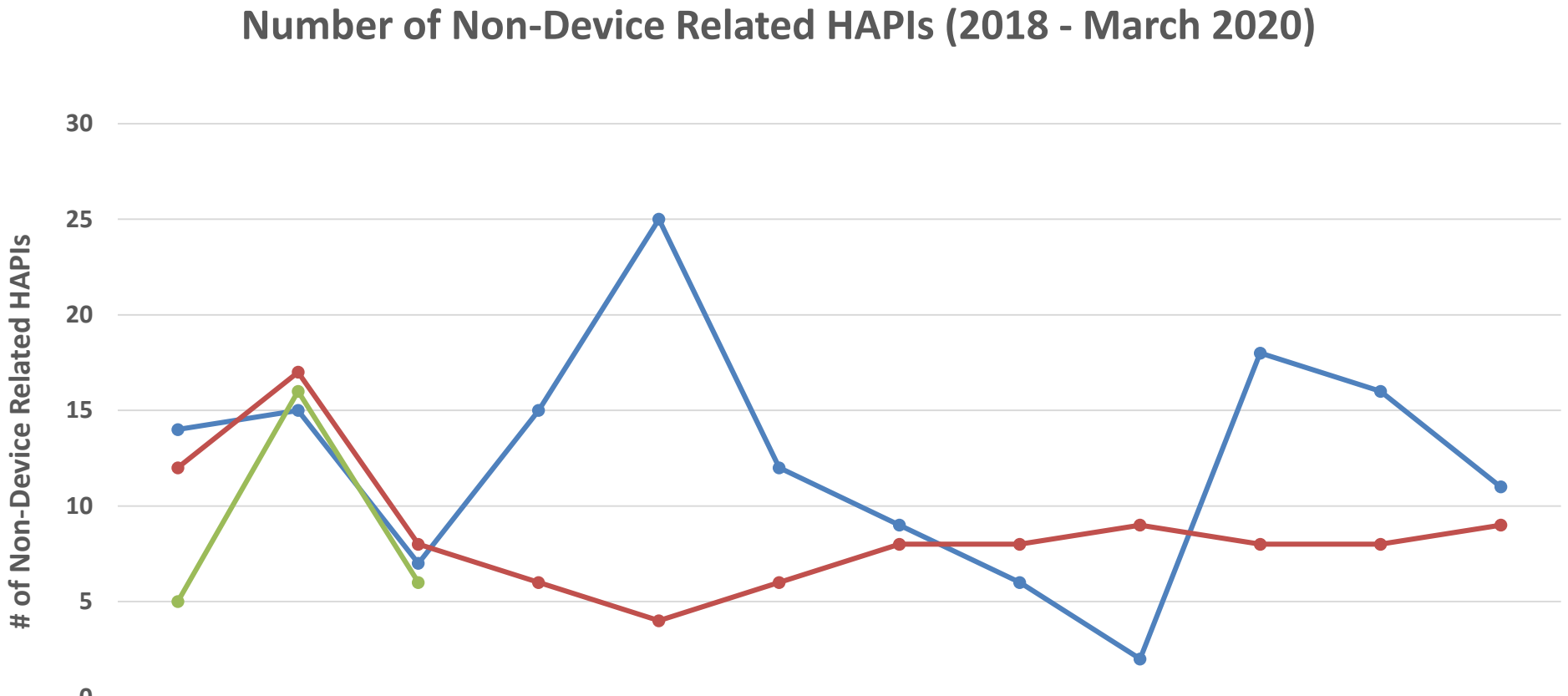
*NPUAP, 2016; *Patent Pending – Patty Turner, BSN, RN, CWOCN, CSW*

HAPIs by Stage (2018-2019)



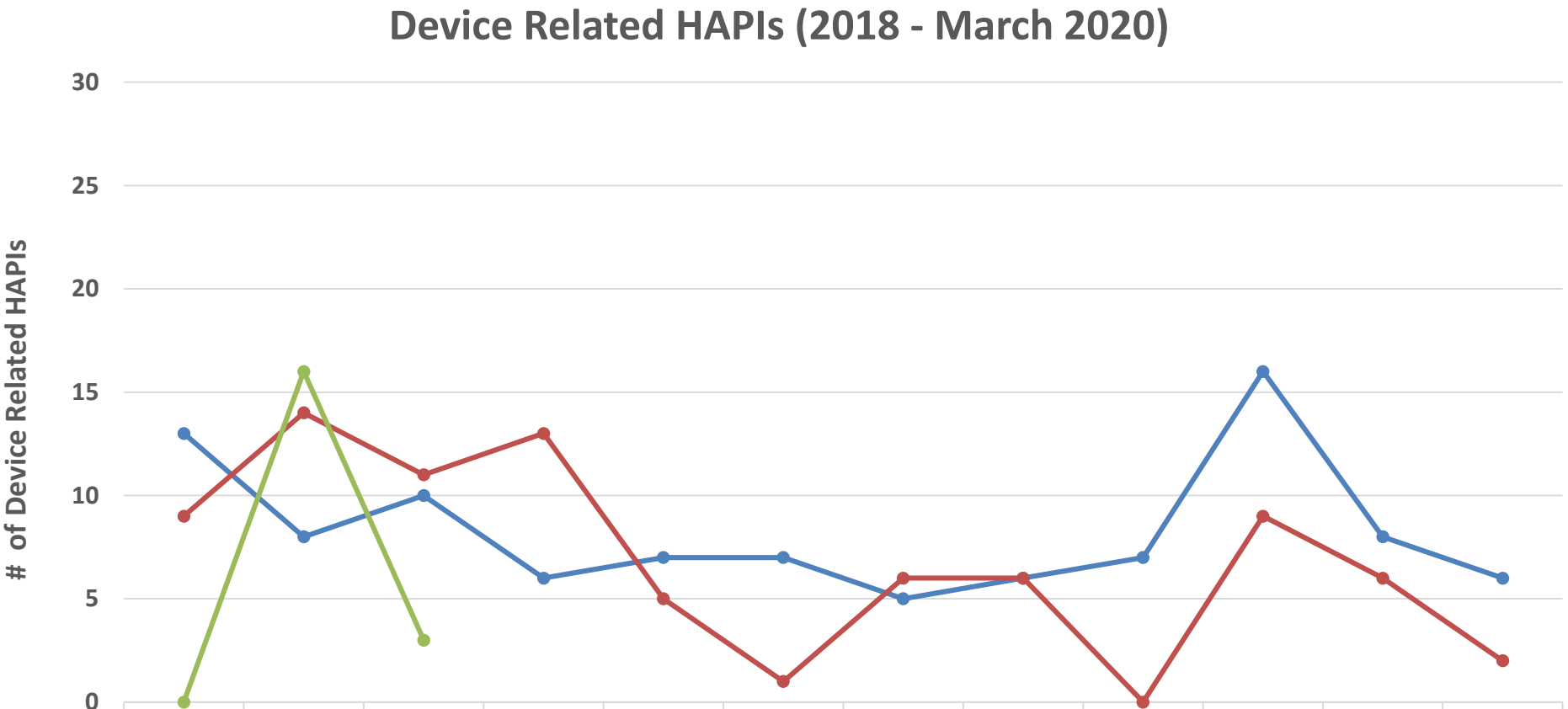
	DTPI	Stage 1	Stage 2	Stage 3	STAGE 4	Unstageable
2018	175	23	38	4	1	13
2019	129	12	20	3	0	21

HAPI: Non-Device Related



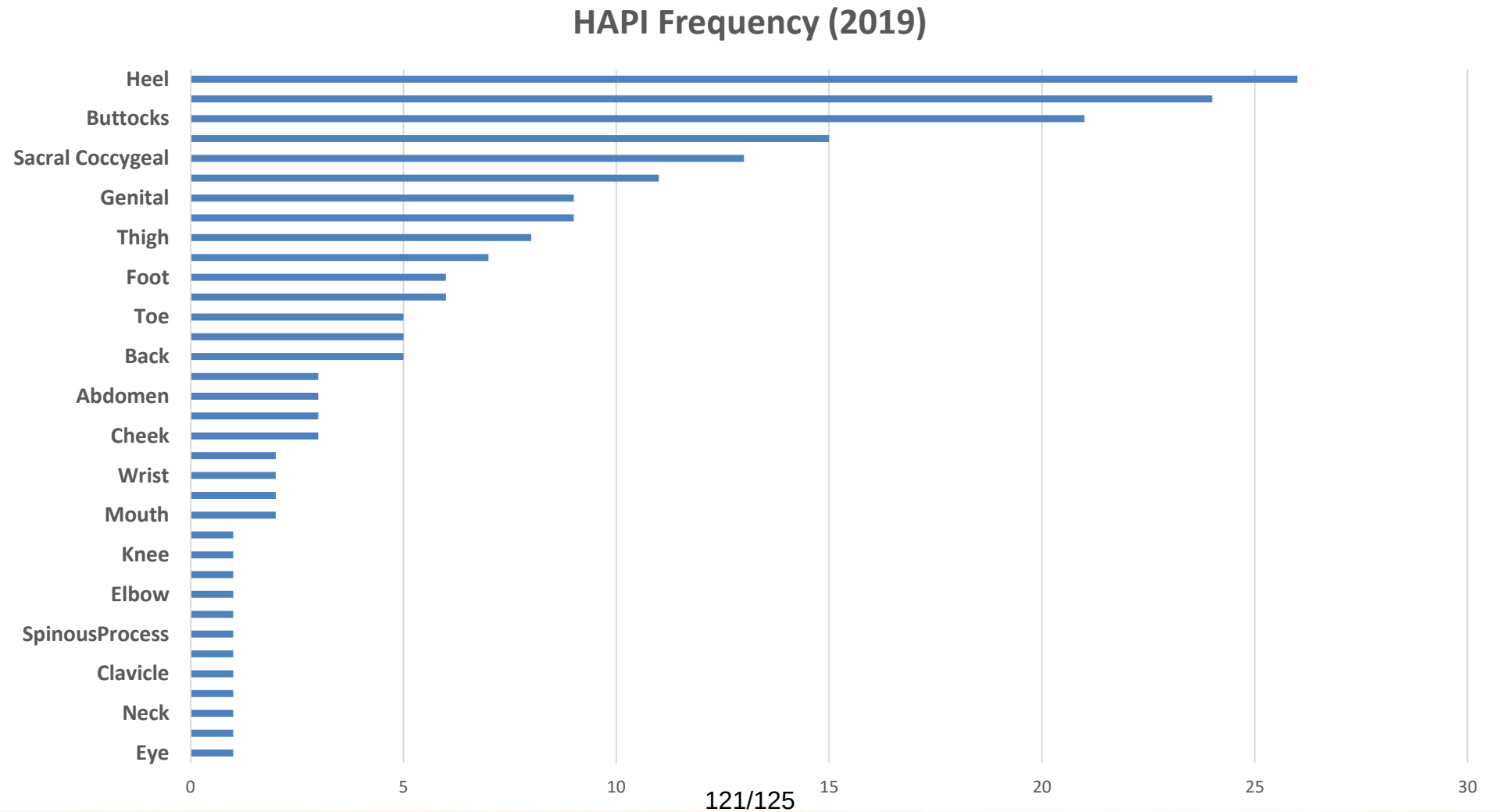
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	14	15	7	15	25	12	9	6	2	18	16	11
2019	12	17	8	6	4	6	8	8	9	8	8	9
2020	5	16	6									

HAPI: Device Related



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	13	8	10	6	7	7	5	6	7	16	8	6
2019	9	14	11	13	5	1	6	6	0	9	6	2
2020	0	16	3									

HAPIs by Location (2019)



Braden Risk Assessment Tool

- Six subscales, each scored between 1 and 4
  - Sensory perception
  - Moisture
  - Activity
  - Mobility
  - Friction
  - Shear
- The lower the score, the greater the risk

Role of Wound Nurse Team

- Current State
  - Educate
  - Consult
  - Treat
  - Data Collection
- Future State
  - Move from consultative “post-HAPI” role to predictive preventive role

HAPI Kaizen

August 25-28, 31

Kaizen Event Goal:

- Lean Six Simga strategy, rooted in manufacturing
- Kai (good) zen (change) means “Change for the Good”.
- **Goal:** Execute a focused and effective event that accomplishes the objectives in a short time frame and utilize the opportunity to further develop participants as effective problem solvers.
  - all solutions/improvements are implemented in the Kaizen or ideally within 30 days of event